Health Disparities

Goal for the Year 2010: Eliminate health disparities for racial and ethnic minorities, women, people with low incomes and people with disabilities.

Overview

Race, ethnicity and income are significantly associated with health disparities in Lincoln and Lancaster County as well as the state and nation as a whole. The national Healthy People 2010 has established two overarching goals: increase quality and years of healthy life and eliminate health disparities. The Lincoln–Lancaster County Board of Health and the Healthy People 2010 Community Steering Committee embraced these goals for Lancaster County in January 1999.

Eliminating disparities is a bold step forward from the goal of Healthy People 2000, which was to reduce disparities in health status, health risks and use of preventive interventions among population groups. Thus, in the Healthy People 2000 process, special population targets were established for racial and ethnic minority groups, women, people with low incomes, people with disabilities, and specific age groups.

In the Healthy People 2010 process, a single target objective is set for each indicator for all relevant populations. An objective will not be considered achieved unless it is achieved for all population groups.

Eliminating disparities by the year 2010 will require new knowledge about the determinants of disease and effective interventions for prevention and treatment. It will also require improved access for all to the resources that influence health. Reaching this goal will necessitate improved collection and use of standardized data to correctly identify all high-risk populations and monitor the effectiveness of health interventions targeting these groups. Research is needed to better understand the relationship between health status and income, education, race and ethnicity, cultural influences, environment, and access to quality medical services. This will help us acquire new insights into eliminating the disparities and developing new ways to apply our existing knowledge toward this goal.

Achieving the goals of eliminating health disparities and increasing quality and years of healthy life will require a national, state, and local commitment to identify and address the underlying causes of higher levels of disease and disability in racial and ethnic minority communities. These include poverty, lack of access to quality health services, environmental hazards in homes and

neighborhoods, and the need for effective prevention programs tailored to specific community needs as well as the underlying or pervasive effects of racism.

To be successful in meeting this challenge, intentional privilege may be necessary to assure that minorities get appropriate and necessary health care. The goal is not just to decrease disparities but to increase quality and years of healthy life for all populations.

In some cases, achieving the Healthy People 2010 objectives will not be possible without success in improving health status for special populations. For example, in order to effectively reduce the rate of low birth weight infants or teen births requires an emphasis on minority and low-income women and families. To change the proportion of adults as well as the proportion of youth who smoke requires efforts targeted to youth.

In this chapter, you will find a summary of key disparities in health status. These are discussed in more depth in every chapter of the document.

What you will not find are different targets or objectives for minority populations. Instead, the intent is to identify the magnitude of disparity and to regularly report on progress toward narrowing the gap. Over the next ten years, annual reports will be issued showing progress toward the ultimate goal of eliminating the disparities (gap).

Several indicators do not yet have data available to specifically identify differences by race or ethnicity. These indicators are very important to tracking the health of a population. Data is currently being collected for two indicators through the 2000 Minority Behavior Risk Factor Survey and the 1999 Adult Behavior Risk Factor Survey. The 2000 census data is expected to have sufficient information to calculate age-adjusted and poverty rates by age, sex, and race. And finally, new sources of data are being developed to track progress in oral health and immunizations in minority populations.

Table 1 contains a summary list of key indicators which most effectively illustrate existing disparities associated with race and ethnicity. The table will show the current gap between the highest rate and the lowest rate. The subpopulations (White, Black, Asian, Hispanic and Native American) with the highest and the lowest rates are identified. For several indicators, data is currently not available to distinguish rates for each of the minority subpopulations. In those cases, the rates are shown for white and minority populations.

Table 2 presents the most recent Lancaster County data for these indicators selected by each major ethnic and racial group.

Population demographics

The racial and ethnic fabric of Lincoln and Lancaster County has undergone rapid change in recent years. Once a predominantly White community, the population is now more diverse and multiethnic. Racial and ethnic minorities are currently estimated to be slightly less than ten percent of the county population. In the past ten years, Lancaster County has experienced a population growth (12.2%). The percent of increase in the minority population (51.0%) was over six times greater than the percent of increase in the white population (8.4%).

Between 1990 and 1998, 4,777 refugees were resettled in Lincoln and Lancaster County. Over half of the refugees resettled were from Asia, which included: 2,036 Vietnamese, 936 Amerasians, and 67 Laotians. People from Iraq and Bosnia/Herzegovina and

Table 1. Health Disparities

Disparities in health status associated with race and ethnicity
(degree of disparity is the gap between the highest and lowest rates)

	Gap	High Rate		Low Rate	
Age-adjusted diabetes deaths per 100,000 population[1]	43.3	55.9[2]	Minority	12.6[2]	White
Age-adjusted breast cancer deaths per 100,000 population[4]	--	--[3]		--[3]	
Age-adjusted coronary heart disease deaths per 100,000 population[5]	246.9	335.9[2]	Minority	89.0[2]	White
Percent of adults overweight	--	--[6]		--[6]	
Gonorrhea incidence in persons 15–24 years of age per 1,000 population	31.1	32.2[7]	Black	1.1[7]	White
Percent of adults who smoke cigarettes	22.7	44.2[9]	Native American	21.5[9]	Asian
Percent of persons aged 18–25 reporting binge drinking	51.9	72.4[9]	Hispanic	20.5[9]	Black
Infant deaths per 1,000 live births	10.5	16.9[10]	Black	6.4[10]	White
Percent of births that are low birth weight	7.8	14.1[10]	Black	6.3[10] 6.4[10]	White Asian
Percent of mothers *not* receiving first trimester prenatal care	21.1	35.8[2] 34.2[2]	Black Native American	14.7[2]	White
Percent of children aged 19–35 months who are adequately immunized	--	--[12]		--[12]	
Percent of persons aged 65 and older receiving pneumonia and flu immunizations	--	--[6]		--[6]	
Percent of women *not* receiving cervical cancer screening within the past three years	14.7	95.9[9]	Asian	81.2[8]	White
Percent of women *not* receiving mammography screening for persons 40 and older within the past two years	25.2	88.9[9]	Asian	63.6[9] 65.5[8]	Hispanic White
Percent of adults *without* health insurance coverage	37.0	46.1[9]	Native American	9.1[8]	White
Percent of adults who report that they have been told they have hypertension	15.1	22.8[9]	Black	7.7[9]	Asian
Percent of adults who report that they have been told they have high cholesterol	9.6	24.0[9] 23.6[9]	Hispanic Black	14.4[9]	Asian
Percent of adults who report that they have been told they have diabetes	11.9	15.8[9]	Black	3.9[8]	White
Suicides per 100,000 of population	4.1	10.9[2]	White	6.8[2]	Minority
Percent of school children aged 6–18 who have *not* seen a dentist in the past 12 months	--	--[12]		--[12]	
Percent of children under age 18 who live in poverty	--	--[12]		--[12]	
Average age of death for females	26.6	77.5[16]	White	50.9[16]	Hispanic
Average age of death for males	20.8	69.1[16]	White	48.3[16]	Asian

Table 2. Health Disparities

Key indicators of health status in Lancaster County by race and ethnicity categories

Lancaster County Recent Data	Total	White	Black	Native American	Asian	Hispanic	Minority
Age-adjusted diabetes deaths per 100,000 population[1]	13.6[2]	12.6[2]	--[3]	--[3]	--[3]	--[3]	55.9[2]
Age-adjusted breast cancer deaths per 100,000 population[4]	16.6[2]	--[3]	--[3]	--[3]	--[3]	--[3]	--[3]
Age-adjusted coronary heart disease deaths per 100,000 population[5]	103.7[2]	89.0[2]	--[3]	--[3]	--[3]	--[3]	335.9[2]
Percent of adults overweight	--[6]	--[6]	--[6]	--[6]	--[6]	--[6]	--[6]
Gonorrhea incidence in persons 15–24 years of age per 1,000 population	2.5[7]	1.1[7]	32.2[7]	2.9[7]	1.2[7]	4.3[7]	14.7[7]
Percent of adults who smoke cigarettes	21.9[8]	22.3[8]	31.8[9]	44.2[9]	21.5[9]	24.9[9]	28.7[9]
Percent of persons aged 18–25 reporting binge drinking	32.0[8]	34.3[8]	20.5[9]	22.1[9]	30.7[9]	72.4[9]	25.3[9]
Infant deaths per 1,000 live births	7.0[10]	6.4[10]	16.9[10]	12.2[10]	9.2[10]	14.3[10]	12.3[10]
Percent of births that are low birth weight	6.7[10]	6.3[10]	14.1[10]	7.7[10]	7.4[10]	6.4[10]	9.8[10]
Percent of mothers receiving first trimester prenatal care	83.8[2]	85.3[2]	64.2[2]	65.8[2]	72.9[2]	76.2[2]	68.7[2]
Percent of children aged 19–35 months who are adequately immunized	74.0[11]	--[12]	--[12]	--[12]	--[12]	--[12]	--[12]
Percent of persons aged 65 and older receiving pneumonia and flu immunizations	73.2[13]	--[6]	--[6]	--[6]	--[6]	--[6]	--[6]
Percent of women receiving cervical cancer screening within the past three years	18.5[8]	18.8[8]	9.5[9]	10.0[9]	4.1[9]	11.4[9]	6.9[9]
Percent of women receiving mammography screening for persons 40 and older within the past two years	34.5[8]	34.5[8]	28.2[9]	25.0[9]	11.1[9]	36.4[9]	20.0[9]
Percent of adults with health insurance coverage	90.0[8]	90.9[8]	78.2[9]	53.9[9]	68.7[9]	65.2[9]	71.4[9]

Lancaster County Recent Data	Total	White	Black	Native American	Asian	Hispanic	Minority
Percent of adults who report that they have been told they have hypertension	18.7[8]	19.2[8]	22.8[9]	19.1[9]	7.7[9]	8.7[9]	15.9[9]
Percent of adults who report that they have been told they have high cholesterol	16.7[8]	16.9[8]	23.6[9]	20.3[9]	14.4[9]	24.0[9]	21.1[9]
Percent of adults who report they have been told they have diabetes	3.7[8]	3.9[8]	15.8[9]	4.5[9]	5.8[9]	5.5[9]	8.0[9]
Suicides per 100,000 population	10.7[2]	10.9[2]	--[3]	--[3]	--[3]	--[3]	6.8[2]
Percent of school children aged 6–18 who have seen a dentist in the past 12 months	71.3[14]	--[12]	--[12]	--[12]	--[12]	--[12]	--[12]
Percent of children under age 18 who live in poverty	11.1[15]	--[12]	--[12]	--[12]	--[12]	--[12]	--[12]
Average age of death for females	77.0[16]	77.5[16]	59.5[16]	57.2[16]	57.0[16]	50.9[16]	58.6 [16]
Average age of death for males	68.5[16]	69.1[16]	55.4[16]	55.3[16]	48.3[16]	59.6[16]	53.6 [16]

other former Soviet lands were also among the leading nationalities being resettled.

The number of students taking English as a second language increased 261% during these years. In the 1997–1998 school year, at least 35 primary languages were used by children in the ESL program. Nearly 80% of these students spoke either Vietnamese, Spanish, Arabic or Russian.

Even more substantial than overall minority population growth in the county from in-migration has been the increase of minority population births. The annual number of minority resident births increased from 235 births in 1987 to 457 births in 1997. The percentage of total births that are of minority race or Hispanic ethnicity increased from 7.8% in 1987 to 14.2% in 1997. Black, Native-American, Asian and Hispanic populations in Lancaster County experienced significant increases in the number of infants born every year between 1987 to 1997. Of these populations, Hispanics had the largest increase in annual births (125.0%) during this period, followed by Asians (61.2%) and Blacks (46.3%). In 1987, the Black population had the largest number of annual births of all racial and ethnic minorities, but by 1997, Asian and Hispanic births had both grown to exceed the number of Black births.

Income also has an independent and significant impact on health. In Lancaster County minority populations are five times more likely to live in poverty than the White population. Large proportions of Lancaster County women lack health insurance – particularly minority women (one in three) and low-income women (one in five). Lancaster County has seen increases in three demographic factors that have an important impact on health care access, ethnic diversity, poverty and female-headed households. Large proportions of female-headed households live in poverty (one in four), especially those with children (one in three). One-half of female-headed minority families live in poverty – more than twice the percentage for White female-headed families (22%). The majority (71.5%) of female-headed minority families with children younger than five years old live in poverty compared to 40.7% of White families with similar characteristics. Among female headed households and female-headed households with children, Hispanic households are most likely to be in poverty (80.3%), followed by Native-American (77.8%) and Black households (45.2%).

Health Status

The disparities in health status that are associated with race, ethnicity and income are discussed throughout the *Healthy People 2010* document. Each of the following chapters has a section titled Health Disparities. The following bulleted statements summarize key disparities identified and discussed in more depth in these chapters.

- In Lancaster County, infant mortality (IMR) is higher than the minority population than the White population, but this difference is not statistically significant, due to the relatively small number of minority deaths involved. (IMR for 1989–1996)

  9.6 deaths per 1,000 births for minority population
  7.3 deaths per 1,000 births for White population

- The higher infant mortality rate in the minority population is entirely attributable to high infant mortality in the Black population. (IMR for 1989–1996)

18.4 deaths per 1,000 births for Black population

- In contrast to overall decreases in infant mortality, the percentage of infants born with low birth weight (LBW) has gradually, but steadily increased. In Lancaster County, the percentage of low birth weight infants reveals a statistically significant increase from 5.3% in 1991 to 6.9% in 1995. Low birth weight is more prevalent among minority than among White infants. (LBW for 1989–1996)

  8.8% of all minority infants
  5.5% of all White infants
  13.7% of all Black infants

- In Lancaster County, White women are significantly more likely than minority women to receive first trimester prenatal care. (1989–1996)

  87.4% of White women
  76.9% of minority women

- Native-American and Black mothers are the least likely to receive first trimester prenatal care (64.3% and 67.4% respectively in 1989–1996).

- The average age of death (1991–1995) for racial and ethnic minority females (57.5 years) in Lancaster County is approximately 20 years younger than for White females (77.0 years). This is a larger disparity than the 17.1 year difference between White males (68.9 years) and non-White males' (51.8 years) average age of death.

- Among women 50 years and older, 37.7% of White women, 34.9% of racial and ethnic minority women have had an age-appropriate mammogram. (1994)

- Age-adjusted death rates by racial group are difficult to calculate for Lancaster County due to small population and case sizes involved. But in Nebraska, age-adjusted death rates for heart disease and stroke are significantly higher for Black and Native-American populations than for the White population.

- Local behavioral risk factor survey data for both minority and general populations (1993 and 1994) demonstrate vivid contrasts in cardiovascular-relevant behaviors, screening indicators, and health care system access in Lancaster County.

  1. Smoking, binge and heavy drinking, and lack of exercise are more prevalent among in the minority population than in the White population. Elevated smoking prevalence stands out among Black adults, while binge and heavy drinking is significantly elevated for all minority groups in comparison to the White population. Exercise rates are lowest among Blacks and Native Americans.

  2. Native Americans were more likely than any other major racial group to have been told that they have high cholesterol, both as a percentage of total respondents and as a percentage of those who had ever had their cholesterol checked.

  3. Hispanic and Native Americans were less likely than Whites to report having had their blood pressure checked during the past year, and Blacks were most likely to have been told that they have high blood pressure.

  4. Hispanic, Native Americans and Blacks were more likely than Whites to report that they had been told they had diabetes.

  5. In 1994, 17.2% of the racial and ethnic minority population reported not accessing care in the prior year because of cost compared to 8.5% of the White population.

6. Hispanic, Black, and Native-American respondents (BRFS) were far more likely to report lack of health care coverage and inability to see a doctor due to cost.

7. Native Americans were most likely to report not having had an annual checkup and difficulty obtaining transportation for care.

8. Black respondents were most likely to report that racial and ethnic origin is a barrier to receiving services.

9. Hispanic and Native-American respondents were most likely to report that their fair or poor English language skills prevented them from receiving health care services.

10. The prevalence of obesity is particularly high in minority populations, especially among women and low-income persons. Currently, about 47% of Hispanic and 49% of Black women are classified as overweight.

11. Childhood obesity has been increasing since the 1970s, with the result that 21% of all 12 to 19 year-olds are now seriously overweight.

12. Disparity in access to care most affects young adults between the ages of 18 and 24.

13. According to the YRBS, during the past ten years minority or Hispanic students have consistently reported greater rates of use for marijuana and "other illegal drugs" than have their White counterparts.

- Many poorer and less economically developed neighborhoods in Lancaster County have higher percentages of ethnic and minority populations than other areas of the county. Higher concentrations of alcohol outlets are typically found in these poorer neighborhoods. Evidence shows that areas with greater alcohol outlet densities have greater alcohol-related crashes, assaultive violence, youth violence, and alcohol-related pedestrian injuries.
- The rate of asthma hospitalizations in 1995 showed increases over the baselines of 188 per 100,000 for two special population groups – Blacks and all children aged 14 and younger.
- Young children who are poor are disproportionately exposed to sources of lead poisoning and are found to have elevated blood lead levels due to living conditions in old rental properties or poor-lifestyle environments.
- The national mortality rate from cardiovascular disease (CVD) (1995) shows that Blacks have a 40% higher CVD mortality rate than the White population whose disease mortality rate is 40% higher than the Asian population.
- Women who have had a heart attack have poorer health outcomes in general than males who have had a heart attack.
- Nationally, age-adjusted stroke mortality is almost 80% higher in Blacks than in Whites and about 17% higher in males than in females. Moreover, age-specific stroke mortality is higher in Blacks than in Whites in all age groups up to age 84 and higher in males than females throughout all adult age groups.
- In Nebraska, the cancer mortality rate continues to be higher among Blacks than the rates for people of all other races or ethnic origins (1988–1992). The incidence of cervical cancer is higher in both Hispanic and Vietnamese populations than in the White population nationally.
- The prevalence of diabetes is greater in ethnic minority populations including Black, Hispanic, Native-American and Asian groups. Furthermore, these

populations are also at greater risk of developing complications associated with the disease.

- Nationally, among children aged 6–8, 72% of Native-American/Alaskan-Native children, 50% of Hispanic children, 34% of Black children, and 31% of all children experience untreated dental decay.
- National survey results show that 20% of children from families with low incomes and 43% of children in some Native-American populations have baby bottle tooth decay (early childhood caries).
- Recent national studies have disclosed that the overall dental health status of older adults is not good, and that poor oral health is a barometer for general health problems in this population.
- Despite a general reduction in tooth loss in the nation's adult population, 25% of Native Americans and Alaska Natives aged 35 through 44 have fewer than 20 natural teeth; among those aged 55 and older, nearly 75% have fewer than 20 natural teeth.
- Nationally, prevalence of gingivitis is high among Hispanics, Native Americans, and adults with low incomes. The prevalence and severity of periodontal disease increases with age and varies by socioeconomic status.
- Only about half of the people with oral or pharyngeal cancer survive more than 5 years. Tobacco use, especially when combined with heavy alcohol use, is the major risk factor for more than 75% of oral and pharyngeal cancer in the United States. Minorities experience worse outcomes, i.e., Blacks have a much poorer 5-year survival for oral and pharyngeal cancer than Whites (31% vs. 55%). Blacks are less likely than Whites to have regular dental visits.
- When disasters strike a community, those citizens who are at greatest risk are sensitive populations, the homebound, the frail, and the elderly who cannot adequately protect themselves. (The sensitive populations include people in facilities like hospitals, prisons, nursing homes, churches, schools and recreation facilities, any other place where people rely on others to determine their safety).
- Nationally there has been a significant increase in the number of foods imported into the United States. However the present resources for inspection and sampling of the imported foods has not kept up with the demand. The probability is therefore increased that the imported food has been processed in a way that is not equal to standards set by United States Department of Agriculture. Because a majority of this food is consumed by racial and ethnic minorities, it could cause an increased probability for foodborne illness.
- "Environmental Health Hazard Risks In The Minority Community," a study done by the LLCHD in 1997 revealed the following influences on the risk of exposure to toxic and hazardous materials in the minority populations in Lincoln:

  1. The use of hazardous materials for purposes other than their intended use. An example is using gasoline for cleaning car parts.

  2. Accumulation of hazardous materials as a form of wealth.

  3. Consumption of fish from water sources that may contain toxic pollutants. Increased health risks are posed to the Asian population by significantly higher consumption (daily) of fish and reliance on fishing from local water bodies.

4. Distrust of the safety of public drinking water.

5. Lack of familiarity with public facilities for hazardous waste disposal.

- Although childhood immunization rates have been historically lower in minority populations, there has been a significant narrowing of the gap.
- Tuberculosis occurs at higher rates in refugee populations from areas of the world where it is endemic.
- Unintentional injuries are the second leading cause of death for Native-American men and the third leading cause of death for Native-American women.
- Among children, ages 14 and under, Native-American children have the highest unintentional injury death rate in the United States and are two times more likely to die from unintentional injury than White children. Factors that contribute to higher death and injury among Native-American children are more strongly associated with economic conditions than culturally-based differences in parenting.
- Black children aged 14 and under have the second highest unintentional injury death rate in the U.S. and are 1.7 times more likely to die from unintentional injury than White children.
- Children aged 10 and under are injured from falls at a rate of about twice that of the total population. Black children aged 14 and under have a fall-related death rate that is one and a half times higher than that of White children.
- Black children are more than three times as likely and Native-American children are more than two times as likely as White children to die in a fire. Children aged 4 years and under and children with disabilities are at the greatest risk of burn-related death and injury.
- In Lancaster County, the White population has a suicide rate of 12.9 compared to the Black rate of 10.0; Native American, 9.7; Asian, 9.6; and Hispanic, 8.0. (1997)
- Although Black youths have historically had lower suicide rates than have Whites, during 1986–1995, the suicide rate for Black youths, aged 10–19 years, increased from 2.1 to 4.5 per 100,000 population – a 114% increase. Suicidal behavior among all youths has increased in the U.S. during 1980–1995; however, rates for Black youths have increased more.
- Despite having more problematic health conditions on average, older racial and ethnic minority individuals are less likely than nonminority elders to have health insurance or to visit a doctor.
- Barriers to health improvement for certain ethnic groups include the inability to speak or read English, illiteracy in their native language, and a lack of interpreters or bilingual health-care professionals. Lack of knowledge about where and how to access needed services and difficulties in using services because of distance, lack of transportation, or physical impairment also exist.
- The percentage of White births that are teen births has gradually declined in recent years (1987–1995), while the percentages of Asian, Hispanic, and Black teen births have gradually increased.
- Some sexually transmitted disease rates are disproportionate in some minority communities, for example AIDS cases in the Black and Hispanic populations are at higher rates than

their respective percent of the total population. In Lancaster County, 17% of AIDS cases reported were among people of color. The percent of HIV cases reported in Lancaster County among people of color is 24%.

- Large disparities still exist, especially among young people. In 1997, more than 3% (greater than 3,000 per 100,000 population) of young Blacks (15 to 24 year old) had gonorrhea. This compares to 130 per 100,000 for Whites 15 to 19 years old and 104 for Whites 20 to 24 years old. In 1998, young Blacks (15–24 year old) accounted for 19% of all reported gonorrhea cases in Lancaster County, while young Whites accounted for 29% of reported gonorrhea cases.
- National data from 1995 reveal several disparities in smoking prevalence among adults. Men (27.0%) are significantly more likely to smoke than women (22.6%). Native Americans/Alaska Natives (36.2%) are more likely to smoke than other racial and ethnic groups.
- Among adolescents, smoking rates differ between Whites and Blacks. In the 1980s, Black youth showed markedly lower rates of smoking than rates among White teens which were more than three times higher. In recent years, smoking has started to increase among Black male teens but Black female teens continue to have smoking rates considerably lower. Data from the national YRBS indicate that in 1997, 40% of White high school females were smokers compared to 17% of Black high school females.
- Smokeless tobacco use among adolescents also differs significantly by students' gender and race. In 1997, 15.8% of male high school students used smokeless tobacco, compared to only 1.5% for female high school students. Smokeless tobacco use was 12.2% for non-Hispanic Whites, 2.2% for Blacks, and 5.1% for Hispanics.
- Because refuse service is not automatic nor required for single family homes or duplexes, many rental residences do not have refuse service. This most strongly affects the minority and low-income populations in Lincoln.

Community Input

Over the last five months, meetings and focus groups have been held with representatives of four minority groups (Asian, Hispanic, Black and Native American) and people with disabilities. Their insight and feedback has been invaluable to identifying and describing concerns and issues of disparities in health. Some of this feedback is discussed below.

Minority community leaders reminded participants that statistical information is not the only or even the most reliable source of information about a population. It is even more important to understand what the data means, what the implications are and what can be done. Economic status and political power are most critical to changing health status.

Cultural wisdom and knowledge has rarely been valued by the health care community according to many of the participant in meetings and focus groups. The health care system generally has tried to make minority people fit into the health care system box. With the changing population dynamics of this community, it is important for all of us to learn to do business outside of this

box. Culturally competent care needs to be routinely available in Lancaster County.

Ignorance, insensitivity, mistreatment, indifference, and discrimination are adjectives used by many respondents in describing their experiences with the health care system in our community. The inability to communicate (to understand and be understood) across languages and across cultures was cited often.

Several examples of problems experienced by people of color when medical care is primarily focused on serving Euro-Americans include: delayed diagnosis of certain conditions; inability to identify rash illnesses for person of color; and inadequate information about how to care for skin and hair of black infants. A group of black women all shared their common frustration and experience of questions from hospital staff when their children were born. Because a black newborn child's skin is usually much lighter at birth, hospital staff would ask often the mothers who the father really was.

Another area of concern raised was whether specific conditions are recognized or diagnosed in a timely manner. Many immigrants come from parts of the world where tuberculosis and other infectious diseases are endemic. These individuals may not only have active disease but may experience secondary and tertiary consequences of those diseases many years later. Because the initial infection is usually treated immediately in this country, some individuals experience lengthy delays and significant difficulty in getting appropriate treatment for the longer term effects.

Individuals from Hispanic, Native-American and Asian communities discussed the need for more effective education about risk factors and how to prevent disease. They were very concerned about the lack of knowledge in their families and communities regarding prevention of chronic disease. They also described the struggle of adapting cultural patterns of eating and activity in a predominately white community. They perceived a lack of interest in physical activity or exercise that was not a part of work. Risk of obesity was small in traditional or home cultures when people had physically demanding work and ate a diet light in meat. That is changing as they adapt to the American style of life.

The high risk for chronic diseases such as cardiovascular and diabetes in Black and Native-American populations was discussed. Respondents were concerned about a lack of screening activities; lack of knowledge within the population about the need to be screened and how to reduce risk; and difficulty getting the appropriate level of care once a condition was identified. In the Asian population, the difficulties overcoming cultural factors for women to be screened for breast and cervical cancer were identified. Hispanic women discussed their concerns about finding ways to persuade their husbands and fathers to use the health care system. They described a strong cultural tradition (machismo) for men to ignore physical problems of their own and concentrate on supporting and taking care of the family.

Keen interest was expressed by many in increased availability of opportunities for physical activity, especially for children and youth, in schools and in the community. Membership in health clubs and regular opportunities for exercise for adults was desirable but seemed out of reach to most of the respondents.

Concern was expressed about the density of alcohol and tobacco outlets in the low-income areas of town. The perception of many respondents was that the increased density sends the wrong message to their young people and increases access for young people to those products.

Discussion of problems with commu-

nication focused on translation and interpretation. Many individuals expressed concern about the accuracy, sensitivity and trustworthiness of the interpreters. In one focus group for the Hispanic community, participants recommended more emphasis on teaching adults to speak English so they could represent themselves. In other groups, participants recommended setting standards and providing training for individuals who would provide interpretation services for people in medical and health care settings.

While access to care was identified as problematic for all types of health care, two areas of particular concern were identified. Mental health services and oral health services are not readily accessible by most low-income individuals. And within most minority communities, there is an added barrier of perception that it is not needed. However, community leaders in all four minority groups identified culturally appropriate mental health services as a growing and critical need.

When discussing lack of health care coverage, two groups were identified by respondents as having greater difficulty than others: (1) men between 18 and 40 years of age and (2) immigrant elders who did not qualify for Medicare. There are currently insurance programs that cover most children and many women but there is nothing for men if their employment does not include health insurance. Many immigrant elders do not qualify for Medicare and cannot find employment which would include health insurance.

Both community leaders and focus group respondents discussed concern about how funding for services to minorities was distributed. Many expressed a desire to see more community-based programs that were developed and implemented within their own community.

Two of the focus groups highlighted problems specific to persons with disabilities. These included transportation for medical and other needs and barriers created by lack of curb cuts or curb cuts that are improperly designed. Inadequate availability of assisted living facilities was also identified. And they pointed out that many shopping and recreational facilities do not have adequate handicapped accessibility.

Concerns about environmental hazards were discussed. Many centered on conditions of rental housing in low-income areas. The lack of control and inability to get landlords to fix roofs, repaint, provide trash pick-up, and clean up unsafe conditions is a serious concern. Long-time residents in low-income areas of the community also shared their general distrust of government at all levels. They cited examples which included their experience the North East Radial issue. According to one minority leader, “Trust is critical if you want residents to understand potential environmental risks. You have to find the individual(s) within each culture who are trusted and respected if you want environmental health information and education to be accepted.”

Trust, sensitivity, cultural competence, better representation of minorities in the health care work force, greater accessibility to health care, transportation, better housing, and respect were repeatedly emphasized by all participants in minority feedback meetings and focus groups.

Recommendations

These are general recommendations in addition to the specific recommendations found in each of the following chapters:

- Identify, develop and implement adequate data sampling and surveying to track health status of minorities in Lancaster County. Develop analysis and public health comment with the input of advisory groups representing all four minority groups.
- Adopt standards for cultural competence in health care organizations and facilities throughout the community.
- Increase the proportion of health care providers who are members of minority communities.
- Develop standards and training for translators and interpreters who provide translation for medical or health care services.
- Assure that routine preventive health screenings are implemented for those populations most at risk. Educate medical professionals from the student to the community practitioner regarding risk and need for regular screening of these high risk populations.
- Incorporate education about cultural sensitivity into all aspects of educational programs for healthcare providers. Recruitment of medical-school candidates from a variety of cultures can enhance the medical profession in terms of education, information, and the practice of cultural sensitivity.
- Educate consumers so they become active participants in determining their health care status, choices, and options.
- Establish a minority advisory committee to work with the Health Department, Board of Health, Community Health Partners, City, County, and other entities to develop approaches to meet the community health objectives for 2010.
- Rely on minority populations for planning and implementation of health delivery services. Make funding and service decisions with, not for, the communities served. Assist minority communities to identify and obtain funding and other resources.

Notes

Table 1–2

1. Diabetes defined as ICD code 250.
2. Lincoln–Lancaster County Health Department, Vital Statistics data, 1998.
3. Currently no data source. Age-adjusted rates are currently calculated using 1970 national census data as the baseline population. The racial and ethnic breakdowns from the 1970 census are not available.
4. Breast cancer defined as ICD code 174.
5. Coronary heart disease defined as ICD codes 402, 410–414, and 429.2
6. Currently no data source. Data will be available from the 1998 Behavioral Risk Factor Survey and 1999 Minority Behavioral Risk Factor Survey.
7. Lincoln–Lancaster County Health Department, Sexually Transmitted Disease Surveillance data, 1994–1998.
8. Lincoln–Lancaster County Health Department, *Behavioral Risk Factor Survey*, 1994.
9. Lincoln–Lancaster County Health Department, *Minority Behavioral Risk Factor Survey*, 1994.
10. Lincoln–Lancaster County Health Department, Vital Statistics data, 1994–1998.
11. Nebraska Health and Human Services System, Immunization Program report, 1999.
12. Currently no data source. Data source will be developed in 2000.
13. Lincoln–Lancaster County Health Department, *Behavioral Risk Factor Survey*, 1999.
14. Lincoln Public Schools, Screening Report, November 1999.
15. 1995 Small Area Poverty Estimates, U.S. Census.
16. Lincoln–Lancaster County Health Department, Vital Statistics data, 1993–1997.